FLEXIBLE BENEFITS PLAN

Administered by
Connecticut General Life Insurance Company (CIGNA)

INTRODUCTION

The URA/Fermilab Flexible Benefits Plan ("Plan") has been adopted effective January 1, 1993. This booklet represents general information only regarding the terms of the plan.

To help you identify the plan and who to contact when you have questions about the plan, please refer to the following information:

Name of Plan
URA/Fermilab Flexible Benefits Plan

Plan Number
514

Type of Plan
Welfare benefit plan offering health benefits, and medical expense and dependent care reimbursement through a "cafeteria plan" format under Section 125 of the Internal Revenue Code

Plan Year
Calendar Year

Plan Sponsor, Plan Administrator and Agent for Service of Legal Process
Universities Research Association, Inc.
Fermi National Accelerator Laboratory
P.O. Box 500
Batavia, IL 60510-0500
630-840-3396
Attn: Head, Laboratory Services Section

Employer I.D. Number of Plan Sponsor:
52-0816670

Third Party Administrator:
CIGNA Reimbursement Accounts
P.O. Box 0976
Bristol, CT 06010

OVERVIEW OF THE PLAN

Purpose of the Plan
The purpose of the Plan is to offer you the opportunity to have a portion of your compensation from the Sponsor applied toward obtaining various health benefits, dependent care assistance benefits and various insurance benefits for you and your dependents on a before-tax basis. By applying a portion of your compensation in this manner, your taxable income generally is lower. Therefore, your federal and state income taxes and FICA (Social Security) taxes in most cases will be lower. This means more money for you to spend.

Because the income tax laws change frequently, and may affect different individuals in different ways, we cannot assure you that it will be to every employee's advantage to choose to pay for every benefit offered under the Plan on a before-tax basis. Having that choice through the Plan, however, will ensure that you have every opportunity to obtain your share of benefits from the Sponsor by the least expensive means presently available under the law.

Benefits Offered
The Plan permits you to elect to apply a portion of your compensation toward any of the following benefits:

1. Your share of any of the medical and dental insurance premiums for URA/Fermilab sponsored welfare plans; and
2. Nonreimbursed health care expenses for treatment of yourself or your family members; and
3. Dependent Care expenses.

The benefits available to be paid for through the Plan are more fully explained later in this booklet.

Irrevocability of Elections
In general, any election you make relating to benefits under the Plan for any plan year must remain in effect throughout that plan year. However, there are important exceptions to this general rule. Under these exceptions, you may change or revoke your election during the plan year if you (i) incur a change in family status

during the plan year, (ii) terminate employment during the plan year, or (iii) suffer a large increase or decrease (20% or more) in the cost or level of benefits of the health insurance plans that you elected. The Plan's election procedures, and the meaning of a change in family status, are explained in greater detail in the section "Changing Your Elections."

ELIGIBILITY

Every individual who is employed by the Sponsor and who is eligible to participate in the group medical and dental programs that the Sponsor maintains under its personnel policies and procedures is eligible. An eligible employee is not required to participate in the Plan. For any plan year, an eligible employee may choose to participate in the Plan with respect to any or all of the benefits offered for which that employee is eligible according to the terms of (i) the applicable medical and dental plans or (ii) the Health Care Reimbursement Plan or Dependent Care Reimbursement Plan.

BENEFITS AVAILABLE

Options

Insurance Premium Benefits

The Sponsor maintains plans for providing employees and their families with certain welfare benefits such as medical and dental coverage. These benefits may be provided under various insurance plans. The Plan enables you to participate in any one or more of these insurance programs and to pay the premiums more cheaply by using before-tax dollars.

You have received a written booklet or certificate explaining your benefit rights under those benefit plans in which you are eligible to participate.

Health Care Reimbursement Plan

Some medical and dental expenses incurred by you and your enrolled family members will not be covered by your group health plan. For example, deductible and co-payment amounts come out of your pocket, as do expenses in excess of reasonable and customary coverage limits and expenses for certain medical and dental procedures or treatments that are excluded from coverage under the health plan. The Plan offers you an opportunity to pay those expenses more cheaply with before-tax dollars. You may elect to have up to $3,000.00 withheld each plan year from your compensation and credited to your Health Care Reimbursement Account to be used to pay uninsured medical and dental expenses for you or your family members. A sample list of these expenses is included at the end of this booklet. Premiums for your health plan coverage may not be paid out of your Health Care Reimbursement Account.

Dependent Care Reimbursement Plan

Amounts may be deposited into your Dependent Care Reimbursement Account to reimburse you for depends care expenses such as child care centers, family day care providers, nursery school, baby sitters, and caregivers for disabled dependents. Your dependent must be either (a) under age 13 and eligible to be claimed as an exemption on your federal income tax return or (b) a spouse or other dependent who is physically or mentally incapable of caring for themselves. Your spouse must work, be looking for work, or attending school full-time. The Plan offers you the opportunity to pay these expenses with pre-tax dollars. You may elect to have up to $5,000.00 ($2,500.00) if you are married but file your income tax return as a single individual) withheld each plan year for this purpose.

One of the advantages of the Plan is that it offers employees choices, so they have the opportunity to elect what is best for their individual circumstances. To make these choices concerning your benefits, you need to consider your personal circumstances carefully. Neither the Sponsor nor the Administrator can give personal tax or financial planning advice, so you may want to consult with your own adviser before making benefit elections under the Plan.

Your Benefit Accounts

You will have the opportunity to elect what amount of your compensation, if any, you wish to contribute towards any of the benefits for which you are eligible that are offered under the Plan. Your elections must be made on an enrollment

form available from the Fermilab Employee Benefits Office.

An account will be established in your name under the Plan for each of the benefits you elect to contribute to. These accounts include the following:

4. a "Health Care Reimbursement Account" for paying uninsured medical and dental expenses for you and your family;
5. a "Dependent Care Reimbursement Account" for paying your dependent care expenses;
6. your contributions for your share of insurance premiums will automatically be deducted from your paycheck on a before-tax basis. If you do not want to pay your insurance premiums on a before-tax basis, you must sign a waiver form.

Your premium deductions must equal your share of the full premium cost for whichever medical and dental coverage(s) you select. If premium rates change mid-year, then your contribution (hence, withholdings from your future paychecks) will automatically be adjusted.

Amounts will be withheld from your paychecks in accordance with your election and credited to your Health Care Reimbursement Account and Dependent Care Reimbursement Account. Your Accounts will be charged as you submit claims for payment. (Claim payment procedures are discussed in the section "Payment of Claims.")

Your claims must be documented by submitting an acceptable description of the health expense and the amount of it from an independent third party (such as a detailed bill from the service provider). You must also submit a written statement that any medical or dependent care expense claim (or any designated part of it) is not covered by your health insurance and that you have not been reimbursed for that expense. If you submit a proper claim for health reimbursement that exceeds the amount contributed to your Health Care Reimbursement Account to that date, that claim will still be paid up to the total amount you elected to contribute to that Account for the whole year reduced for any prior reimbursements.

Your Accounts do not earn interest during the year. They are simply bookkeeping records to keep track of how much has been withheld from your paychecks under the Plan and how much is available to pay for each of your elected benefits.

Unused Amounts

The total amount of funds, if any, remaining in the Health Care Reimbursement Accounts and/or Dependent Care Reimbursement Accounts of all participants after the payment of all claims reimbursements and the administrative expenses of the Accounts shall be forfeited

PARTICIPATION PROCEDURES

Voluntary Participation

Participation in the Plan is completely voluntary. If you are eligible to participate, you may complete an enrollment form available from the Fermilab Employee Benefits Office. If you choose to participate in the Plan, you may designate on the enrollment form which of the benefits offered under the Plan you wish to pay your share of the cost of on a before-tax basis.

You may not elect any benefit for which you are not eligible under the terms of the insurance policy governing that benefit. The Plan simply offers you the opportunity to pay your share of the cost of particular benefits on a generally favorable before-tax basis. It does not alter the conditions for being eligible for the particular benefits offered under the Plan, so it is possible that some eligible employees may not be eligible for all of the benefits offered under the Plan.

Annual Elections

Participation is elected on the basis of the "plan year." Each plan year runs for 12 months. The calendar year is the plan year.

If you are already eligible before the start of a plan year, you should complete and file your enrollment form for that plan year with the Sponsor during the open enrollment period scheduled before the start of the plan year.

IF YOU FAIL TO MAKE AN ANNUAL ELECTION, YOU WILL BE DEEMED TO

HAVE MADE AN ELECTION NOT TO PARTICIPATE IN THE HEALTH CARE REIMBURSEMENT AND DEPENDENT CARE REIMBURSEMENT PLANS FOR THE FOLLOWING PLAN YEAR.

If you fail to waive out of the Premium Conversion portion of the Plan, you will be deemed to have made an election to have your health and dental care premiums paid on a before-tax basis. Your application then will be effective for that entire plan year.

If you first become eligible to participate in the Plan in the middle of a plan year, you may elect to participate for the remainder of that plan year by filing an enrollment form within thirty (30) days after your first day of employment. Your participation will begin on the start of the first payroll period beginning after your application is file.

Changing Your Elections

Once you make an application for a plan year, the elections on that application cannot be changed or revoked during that year unless you have a change in status. A change in status includes:

- your marriage, divorce, legal separation or annulment;
- the death of your spouse or dependent;
- the birth, adoption or placement for adoption of a dependent;
- the start or loss of your employment, your spouse or dependent;
- a change in work schedule, including an increase or decrease in the number of hours of employment by the employee, spouse or dependent, including a switch between full-time and part-time status, a strike or lockout and commencement or return from an unpaid leave of absence;
- a dependent satisfies or ceases to satisfy the requirements for unmarried dependents;
- a change in the place of residence or work site of the employee, spouse or dependent; and
- a significant change in the health coverage available through your spouse's employment.

If a change in status occurs, you may change your elections under the Plan for the remainder of the plan year. However, any such changes must be caused by and consistent with the change in status that occurred.

In addition, if a change in status occurs that entitles an employee, or family member to COBRA continuation of coverage for the Health Care Reimbursement Plan (or coverage under a similar state program) COBRA premiums can be paid on a before tax basis through payroll deductions.

Compensation Reductions

Your share of the cost of whatever benefits you designate on your application form will be withheld from your paycheck for the portion of the plan year to which your application applies.

If you receive reimbursement under the Dependent Care Assistance Plan, you cannot take advantage of the dependent care tax credit for those expenses. You should consult with your tax advisor to determine whether you save more money by taking the tax credit or by participating in the Dependent Care Assistance Plan.

Payment of Claims

The Sponsor or its delegate will provide you with the necessary forms for submitting claims for reimbursement under your Health Care Reimbursement Account and Dependent Care Reimbursement Account. Claims on the appropriate forms (with acceptable documentation of the claims) which are submitted will be paid in a minimum amount of $50.00 as soon as practicable after receipt by the Sponsor or its delegate in accordance with the terms of the Plan. All claims for a plan year must be submitted no later than ninety (90) days after the end of the plan year; provided, however, if you terminate employment during the plan year, you will have until the end of the next fiscal quarter to submit your claims for expenses you incurred prior to your termination of employment. Payment is made to you and not the service provider.

If you believe that you are entitled to a greater benefit than that determined by the Sponsor or its delegate, you may file a claim in writing with the Sponsor or its delegate. The Sponsor through its delegate must, within 90 days after the receipt of

the claim, either allow or deny the claim in writing. The denial must include:

7. The specific reason for the denial and reference to the pertinent Plan provisions; and
8. A description of any additional material or information necessary for you to perfect your claim, the reasons such material or information is needed, and an explanation of the Plan's claim procedure.

If your claim is denied, you or your authorized representative may, within 60 days after the receipt of the denial, write the Sponsor or its delegate to appeal the denial. You may review pertinent documents and submit issues and comments in writing in support of the appeal. The Sponsor's decision on appeal acting through its delegate will be made generally within 60 (and not more than 120) days after receiving the appeal. That decision will be final and binding on participants, dependents, and any other interested party.

In no event will a participant or his family members be entitled to challenge a decision of the Sponsor in court or in any other administrative proceeding unless and until the claim and appeal procedures authorized under the Plan and summarized above have been complied with and exhausted.

MISCELLANEOUS INFORMATION

COBRA Rights

Upon a "qualifying event" such as a termination of employment or divorce, as set forth in the Plan document, the Sponsor will inform the eligible individual how he may continue to participate in the Health Care Reimbursement Plan by making contributions to the Plan on an after-tax basis. An eligible individual who continues to participate in the Health Care Reimbursement Plan will be charged the maximum COBRA monthly premium permitted by law. Your COBRA rights are fully set forth in Appendix B.

Protection against Creditors

To the extent permitted by law and except for monies owed to the Sponsor, no Plan benefit payment shall be subject in any way to alienation, sale, transfer, assignment, garnishment, execution, or encumbrance of any kind and any attempt to accomplish the same shall be void.

Sponsor Authority

The Plan Administrator has the discretion to interpret the Plan and to decide all matters arising in connection with the administration of the Plan including the discretionary authority to make factual determinations. The Sponsor may adopt uniform rules for the administration of the Plan from time to time as necessary or appropriate.

APPENDIX A

Eligible Expenses

Below is a sample list of eligible expenses for which you may be reimbursed from your Health Care Reimbursement Account. A complete list of reimbursable expenses is provided by CIGNA on the web at www.CIGNA.com/FSA.

Medical	Dental/Vision	Miscellaneous Medical
Acupuncture	Braces	Ambulance
Birth control pills	Contact lenses	Braille books/magazines
Chiropractor fees	Dental examinations	Car controls for the disabled
Co-insurance amounts you pay	Eyeglasses	Hearing devices/batteries
Crutches	Eye examinations	Physician prescribed weight loss programs
Dermatologist fees	Solutions for contact lenses	Guide dog and its care
Medical deductibles you pay		Telephone for the deaf
Nurse's fees		Television audio display equipment for the deaf
Over the counter (OTC) medicines and drugs*		Expenses for school or home for the disabled
Psychiatrist/psychologist fees		
Sterilization fees		
Vaccinations		
Vitamins by prescription		

* OTC Medicines and drugs used for the treatment of illness or injury. Only OTC medicines that are used for the diagnosis, cure, treatment or prevention of disease or injury are reimbursable.

Non-Reimbursable Expenses

Below is a sample list of ineligible expenses for which you cannot be reimbursed from your Health Care Reimbursement Account. This is by no means an exhaustive list; please a complete list of reimbursable and non-reimbursable expenses on Cigna's website at www.CIGNA.com/FSA:

- Toothpaste
- Maternity clothes
- Antiseptic diaper service
- Funeral, cremation or burial, cemetery plot, monument, mausoleum
- Illegal operations or drugs
- Divorced spouse's medical bills
- Special food or beverage substitutes
- Bottled water bought to avoid drinking fluoridated city water
- Health dues/membership (unless part of a medically prescribed regimen for a specific condition)
- Domestic help
- Deductions from wages for sickness insurance under state law
- All premiums, including but not limited to premiums for employee's health plan coverage, the employer of the employee's spouse or dependent health plan coverage, life insurance, disability, double indemnity, "loss of earnings," insurance policies, etc.
- Athletic club expenses to keep physically fit
- Tattooing; ear piercing
- Boarding school fees paid for healthy child while parent is recuperating from illness

- Tuition and travel expenses to send a problem child to a particular school for a beneficial change in environment
- Transportation costs of a disabled person to and from work
- COBRA premiums
- Travel costs to favorable climate when you can live there permanently
- Dance lessons advised by doctors as physical and mental therapy or for the alleviation of varicose veins or arthritis
- Scientology fees
- Cost of divorce recommended by psychiatrist
- Cost of hotel room suggested for sex therapy
- Marriage counseling fees
- Veterinary fees for pet
- Babysitting fees to enable you to make doctor's visits
- Weight reduction or stop smoking programs undertaken for general health, not for specific ailments
- Cost of moving away from airport noise by person suffering nervous breakdown
- Cosmetic surgery
- Hair transplants

APPENDIX B

Cobra and Other Continuation of Coverage

Cobra Eligibility

A. A plan member who becomes a qualified beneficiary shall have COBRA continuation of coverage. COBRA coverage shall be provided only where timely election of coverage and timely payment of any required contribution is made.

B. A "qualified beneficiary" means a plan member who loses coverage for the Health Care Reimbursement Plan, because of a qualifying event or any child born to or placed for adoption with the employee during a period of COBRA continuation coverage. The Dependent Care Reimbursement is excluded.

C. "Qualifying event" for an employee means loss of coverage due to termination of employment or reduction of hours worked for reasons other than discharge for gross misconduct. "Qualifying event" for any other plan member means loss of coverage due to one of the following events:

   1. Death of the employee.

   2. A qualifying event for the employee.

   3. Divorce or legal separation.

   4. The employee becomes entitled to benefits under Medicare after the effective date of COBRA coverage.

   5. A dependent child ceasing to qualify as a "Dependent."

Cobra Notices

A. The employee must notify the Plan Administrator within 60 days of any of the following Qualifying Events:

   1. Divorce or legal separation.

   2. A Dependent child ceasing to qualify as a "Dependent."

   3. Approval of total and permanent disability by the Social Security Administration.

The plan administrator shall notify the COBRA administrator within 14 days of receipt of the employee's notice.

A. The employer shall notify the COBRA administrator within 30 days of any other qualifying event.

B. The COBRA administrator shall notify the qualified beneficiary regarding the beneficiary's coverage continuation option within 14 days of the date the COBRA administrator receives notice of the qualifying event. The notice to the qualified beneficiary shall be in a form and shall contain the information required by COBRA.

C. Notification to the employee is deemed notification to all other qualified beneficiaries residing with the employee. Notification to the parent is deemed notification to all minor qualified beneficiaries residing with the parent.

Cobra Election

A. A qualified beneficiary may elect COBRA coverage during the 60 day period immediately following the latter to occur of the date coverage under the applicable benefit program terminates or the date the qualified beneficiary receives notice from the COBRA administrator. A parent with whom a minor qualified beneficiary resides shall be the person authorized to elect coverage on behalf of the minor.

Cobra Premium Contribution

A. The plan member shall be entitled to COBRA coverage only if the contribution determined by the company is timely paid on behalf of the plan member.

B. The company may require a contribution up to 102% of the applicable benefit program cost except that a contribution up to 150% of such

cost may be required for a plan member who has been approved by the Social Security Administration for total and permanent disability benefits. The company shall determine the required contribution in advance for a period of at least 12 months.

C. Contributions on behalf of plan members shall be payable monthly.

D. For the initial contribution on behalf of a plan member to be timely, it must be paid within 45 days of the date of election of coverage continuation.

E. For any subsequent contribution to be timely, the contribution must be paid within 30 days of the due date for the month.

Extent of Cobra Coverage

A. A qualified beneficiary may continue the same coverage under the applicable benefit program as the coverage that is available to similarly situated plan members who have not experienced a qualifying event.

B. If coverage under a benefit program is modified for plan members similarly situated to a qualified beneficiary, the modification in coverage shall also apply to the qualified beneficiary.

End of Cobra Coverage

A. COBRA coverage ends on the earliest of the following:

1. COBRA coverage under the Health Care Reimbursement Plan shall terminate, at the latest, on the last day of the Plan Year in which the qualifying event occurred.

2. The date on which the Employer ceases to provide any group health plan to any Employee.

3. The date on which coverage ceases under the Benefit Program because the Qualified Beneficiary failed to make timely payment of any required contribution.

4. After the date of election, the date on which the Qualified Beneficiary first becomes either:

   a. Covered, as a participant or otherwise, under any other group health plan provided the other coverage begins after the date of the Qualifying Event. COBRA coverage shall not end, however, but shall extend through any period that a pre-existing condition limitation in the other plan materially restricts benefits for the Beneficiary, or

   b. Entitled to Medicare provided the Medicare entitlement occurs after the date of the qualifying event. This provision shall not apply, however, in the case of entitlement to Medicare due to end stage renal disease.

COBRA Administration

A. COBRA administration shall be interpreted and applied in a manner consistent with the Consolidated Omnibus Budget Reconciliation Act of 1985 (“COBRA”).

Other Continuation of Coverage

Coverage under each benefit program shall be continued on the same terms as actively employed in the situations and to the extent set forth below:

A. Disability, Worker’s Compensation or Personal Leave. Coverage is continued during a worker’s compensation, disability, or personal leave to the extent determined by the company in its personnel practices and policies communicated to employees.

B. Military Leave.

Please refer to Personnel Policy Guide, Military Leave Section.

C. Family and Medical Leave. Coverage is continued during leave under the Family and Medical Leave Act provided the employee continues to pays any required contributions on a timely basis.